Toward a Healthier Tomorrow: Competent Health and HIV Care for Transgender Persons

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I am not bad or crazy, I live here in a forest
I see things through a rainbow, for I grew up on dreams.
Some of us never grow, but all of us need to know
There are gardens to bloom in, and there must always be room enough
For all of us.
—Ruby and the Dancer (Baer-Sager & Manchester, 1974)

We are pleased to present Part II of this special issue of *JANAC* on transgender health and HIV care. Reader response to Part I (vol. 20, no. 5) has overwhelmingly been positive. One reader wrote, "I have been reading journals for decades–and I am somewhat jaded, rarely 'wowed.' But when I went online to read this issue, I was truly, truly wowed… Thank you for educating all of us." Part II contains a variety of contributions that address health and HIV care of transgender persons from youth to later life. The articles reflect a range of review, research, education, practice, and programmatic innovations.

Although not specifically addressed as an area of focus, a theme that emerges in several articles in both Part I and Part II of these special issues is the relatively high rates of incarceration among HIV-infected and uninfected transgender persons as a consequence of psychosocial issues, such as substance use, commercial sex work, unemployment, and homelessness. In jails and prisons, transgender persons are subjected to stigma and discrimination, both by corrections staff and other inmates, and face many risks to their health and well-being (Giresi & Groscup, 2006; National Commission on Correctional Health Care [NCCHC], 2009; Renault, 2010). For example, a study by the San Francisco-based Transgender, Gender Variant, and Intersex Justice Project found that 59% of transgender people reported being raped or sexually assaulted in prison as compared with 4% of their nontransgender counterparts (Wallace, 2007).

In response to these problems, the NCCHC (2009) recently published a position statement on transgender health care in corrections settings. The statement recommended the use of nine principles grouped into three categories (i.e., health management, patient safety, and discharge planning) to help ensure the physical and mental health and well-being of transgender inmates.

Health Management

1. The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards developed by professionals with expertise in transgender health (World Professional Association for Transgender Health, 2001). Determination of treatment necessary for transgender patients should be on a case-by-case basis. Ideally, correctional health staff should be trained in transgender health care issues. Alternatively, they should have access to other professionals with expertise in transgender health

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care to help determine appropriate management and provide training in transgender issues.

2. Because inmate-patients may be under different stages of care before incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments for transgender people. Policies that make treatments available only to those who received them before incarceration or that limit GID (gender identity disorder) treatment to psychotherapy should be avoided. Policies that attempt to "freeze" gender transition at the stage reached before incarceration are inappropriate and out of step with medical standards, and should therefore be avoided.
3. Diagnosed transgender patients who received hormone therapy before incarceration should have that therapy continued without interruption, pending evaluation by a specialist when urgent medical reasons to the contrary are absent. Transgender inmates who have not received hormone therapy before incarceration should be evaluated by a health care provider qualified in the area of transgender health to determine their treatment needs. When determined to be medically necessary for a particular inmate, hormone therapy should be initiated and sex reassignment surgery considered on a case-by-case basis. Regular laboratory monitoring should be conducted according to community medical standards.
4. Treatment for genital self-harm or for complications arising from prior surgery or from self-treatment should be provided when medically necessary.
5. Correctional health care providers should provide patient education materials to help transgender patients cope with their diagnosis and treatment.
6. Psychotherapy such as "reparative" therapy or attempts to alter gender identity should not be used. Reparative therapy inappropriately portrays GID as a mental illness and not a medical condition.

Patient Safety

7. In matters of housing, recreation, and work assignments, custody staff should be aware that transgender people are common targets for violence. Accordingly, appropriate safety measures should be taken regardless of whether the person is placed in male or female housing areas.

Discharge Planning

8. Transgender inmates receiving hormone therapy should receive a sufficient supply upon release to last until a community provider assumes care. Referrals should be made to community-based organizations with sensitive and inclusive services for transgender people.
9. Correctional policies for management of transgender inmates should be developed and implemented in partnership with local transgender communities, particularly current and former inmates, and transgender service providers when possible.

It is sad to note that persons in corrections facilities constitute one of the only groups in American society to have a constitutional right to health care (Bednar, 2003). Failure to treat in jails and prisons is construed as cruel and unusual punishment (Panel Debates constitutional right to health care in prisons, 2009). However, health care in a jail or prison depends on the particular facility and staff (AIDS InfoNet, 2010). In Part I of the special transgender issue, Cobos and Jones (2009) addressed how transgender persons can serve as change agents in health care and human rights arenas. Perhaps the principles laid out by the NCCHC (2009) can be used to guide transgender care across all inpatient and outpatient health care settings. More importantly, not all jails and prisons currently offer HIV testing, and some wait to test until release to avoid the high costs of HIV medications (AIDS InfoNet, 2010). Perhaps transgender persons can serve as catalysts to help raise awareness and improve HIV testing and treatment standards in corrections facilities and other settings across the country as well as on an international level.

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